No. 10-37

IN THE
Supreme Court of the United States

MICHAEL HALL,
Petitioner,

v.

RICK THALER,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF THE AMERICAN ASSOCIATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (AAIDD) AND THE ARC OF THE UNITED STATES AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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CAPITAL CASE

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INTERESTS OF THE *AMICI CURIAE*[1]

The American Association on Intellectual and Developmental Disabilities (AAIDD) (formerly The American Association on Mental Retardation, AAMR), founded in 1876, is the Nation's oldest and largest organization of professionals in the field of mental retardation. AAIDD has longstanding concerns about constitutional and statutory protections for people with mental disabilities—and mental retardation in particular—in the criminal justice system. AAIDD (as the AAMR) has appeared as *amicus curiae* before this Court in numerous cases, including *Atkins v. Virginia*, 536 U.S. 304 (2002).

AAIDD is also the organization that has formulated the clinical definition of mental retardation that is used by medical professionals in every state. AAIDD's definition of mental retardation has been used by this Court in resolving legal issues that affect people with mental retardation. *See, e.g., Atkins v. Virginia*, 536 U.S. at 308 n.3; *Heller v. Doe*, 509 U.S. 312, 322 (1993); *Penry v. Lynaugh*, 492 U.S. 302, 308 n.1 (1989); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 442 n.9 (1985). Both as the formulator of the clinical definition of mental retardation and as an

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[1] This brief was written entirely by counsel for *amici*, as listed on the cover, and not by counsel for any party. No outside monetary contributions were made to the preparation or submission of this brief. The parties were notified ten (10) days prior to the due date of this brief of the intention to file. All parties have given written consent to the filing of this brief.

organization vitally concerned about maintaining appropriate professional standards in the diagnosis of mental retardation, AAIDD has a strong interest in the manner in which *Atkins* claims are evaluated by the courts.

The Arc of the United States ("The Arc") is the world's largest community based organization of and for people with intellectual and developmental disabilities. The Arc advocates for the rights and full participation of all children and adults with intellectual and developmental disabilities. It provides an array of services and support for families and individuals and includes over 140,000 members affiliated through 730 state and local chapters across the nation. The Arc is devoted to ensuring the civil rights of and promoting and improving supports and services for all people with intellectual and developmental disabilities.

SUMMARY OF ARGUMENT

This Court has made clear that the Eighth Amendment prohibits the execution of individuals who have mental retardation. The limited task of crafting the procedures under which courts will determine whether a defendant has mental retardation has been left, in the first instance, to the states. The majority of the states have had relatively little difficulty in establishing procedures that are designed to assure even-handed evaluation

of individual claims based on clinical diagnoses and expert testimony.

A few states, however, in addition to selecting implementing procedures, have crafted their own substantive definitions of mental retardation that are incompatible with scientific and clinical understanding. The result is that many individuals who clearly meet the accepted clinical definition of mental retardation are at risk of being sentenced to death and executed. Texas is such a state.

States that adopt non-clinical definitions of mental retardation (usually based solely on lay observations) are abusing the responsibility entrusted to them in *Atkins* and defying a clear constitutional mandate. Amici agree with Petitioner that Texas employs standards and procedures for evaluating *Atkins* claims that are inconsistent with the established scientific understanding of mental retardation. This procedure departs from clinical standards both by employing irrelevant questions to gauge adaptive limitations and by using so-called "environmental factors" to present a false dichotomy in diagnosing mental retardation. Under-protection pursuant to *Atkins* is a growing problem, as other states have departed from the clinical standards for diagnosing mental retardation.

This case provides the Court with an appropriate vehicle to remind lower courts that fidelity to the holding of *Atkins* requires even-handed application of the definition *Atkins* embraced, and requires adherence to the clinical understanding of mental retardation that is its foundation. More importantly,

this case provides the Court the opportunity to confirm that *Atkins* did not give states license to narrow the class of persons who fall within the constitutional prohibition and to exclude some who, in fact, have mental retardation. Unless the Court acts to affirm *Atkins*'s meaning, persons whom any reasonable clinician would deem to have mental retardation will be erroneously and unconstitutionally determined to be death eligible.

REASONS THE WRIT SHOULD BE GRANTED

I. COURTS SHOULD UNDERSTAND AND APPLY THE CLINICAL DEFINTION OF MENTAL RETARDATION.

The broadly-accepted AAIDD definition of mental retardation is the starting point for any discussion of appropriate diagnosis or classification. AAIDD's definition provides: "[Mental Retardation] is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18." AAID, *Intellectual Disability: Definition, Classification, and Systems of Supports* 6 (11th ed. 2010) [hereinafter AAID 2010].[2]

[2] In the 11th edition of *Intellectual Disability: Definition, Classification, and Systems of Support*, AAIDD uses the term *intellectual disability* throughout to replace the previously used term *mental retardation*. The two terms are identical, and the meaning of *mental retardation* has not changed.

(continued onto next page)

A. The Three Prongs of Mental Retardation Under the AAIDD Definition.

A diagnosis of mental retardation requires the evaluation of three separate criteria, or prongs. The first prong involves a "significant limitation" in intellectual functioning, which requires that the measured intelligence of the individual fall approximately two standard deviations below the mean.[3] The measurement of intellectual functioning

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The term *intellectual disability* is now preferred by mental disability professionals, advocates, and others for a number of reasons. But given that the Court's decision in *Atkins* uses the term *mental retardation*, amici continue to use that term in this brief.

[3] *Atkins* noted that "an IQ between 70 and 75 or lower. . . is typically considered the cutoff IQ score for the intellectual function prong of the mental retardation definition." 536 U.S. at 309 n.5 (citing 2 *Kaplan & Sadock's Comprehensive Textbook of Psychiatry* 2952 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000)). It is consistent with the requirements of the American Psychiatric Association's diagnostic manual:

> Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below. . . . It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 41-42 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

is evaluated through careful assessment of the individual's scores on IQ tests. These psychometric instruments allow an experienced clinician to assess whether the individual meets the requirements of the definition's first prong. As discussed in more detail *infra*, because there are minor differences in scoring among the IQ tests employed, and because other factors can affect the reliability of the raw IQ score, the clinical judgment of an experienced mental retardation professional is essential in assuring accuracy in the interpretation of test results. Robert L. Schalock & Ruth Luckasson, *Clinical Judgment* 5-6 (AAMR, 2005).

The second prong of the AAIDD definition requires that an individual must have significant limitations in adaptive behavior to be diagnosed with mental retardation. This requirement is designed to make sure that the individual's IQ score is a reflection of a real-world disability, and not merely a testing anomaly. The focus of the clinical inquiry regarding this second prong is to determine whether there are significant things that the individual being evaluated cannot do that someone without his disability can do. Adaptive behavior is evaluated against a standardized measure that is "normed" on the general population including people with and without mental retardation.

The concept of adaptive skills implies an array of competencies and provides foundation for three key points: (a) the assessment of adaptive behavior is based on the person's typical (not maximum) performance; (b) adaptive skill limitations often coexist with strengths; and (c) the person's

limitations in adaptive skills should be documented within the context of community and cultural environments typical of the person's age peers. As with measuring intellectual functioning, assessing an individual's adaptive skills requires a clinical review by an experienced mental retardation professional, as a comprehensive assessment will likely include a systematic review of the person's family history, medical history, school records, employment records, other relevant information, and clinical interviews with a person or persons who know the individual well.

The third prong of the definition requires that the disability manifest before the age of 18. Application of the third prong is not at issue in this case.

This Court has observed that diagnosing whether an individual has mental retardation is less complex than the diagnosis of many forms of mental illness. *Heller*, 509 U.S. at 321-22. Moreover, there are objective measures of intellectual functioning (IQ tests), as well as a history of performance, behavior, and observations by others regarding deficits in adaptive skills. Individual assessment, however, still requires careful clinical judgment. Schalock & Luckasson, *ante*, at 5-6. Consequently, it is crucial to prevent stereotypes about people who have mental retardation from clouding or distorting individual assessment.

B. The Etiology of Mental Retardation Indicates that the Condition Often Originates on a Postnatal Basis After Environmental Events Occur.

While many lay persons are under the impression that the etiology of mental retardation is solely a genetic condition, genetics cannot explain the cause of mental retardation in every case. Individuals may be born with perfectly normal DNA and still develop mental retardation due to such factors as birth injury, malnutrition, child abuse, or extreme social deprivation. Understanding the cause of mental retardation in these cases requires consideration of social, behavioral, and educational risk factors.

Because the various lower courts in this case implicitly relied on evidence invoking these post-birth risk factors – social, behavioral, and educational (labeled "environmental factors") – in determining Petitioner was not due *Atkins* protection for mental retardation, an understanding of how these environmental factors are often the root cause of mental retardation is critical.

The impairment of functioning that is present when an individual meets the criteria for a diagnosis of mental retardation often reflects the presence of several risk factors that interact over time. Therefore, in evaluating the etiology of mental retardation, the risk factors must be evaluated contextually at different times of the individual's life: prenatal, perinatal, and postnatal. It is important to note, as well, that those individuals

whose mental retardation is caused by these different environmental sources are equally beset with mental retardation as those whose condition is purely genetic in nature.

Especially pertinent to this case are the *social*, *behavioral,* and *educational* risk factors that occurred in the postnatal stages of Petitioner's life. The postnatal *social* risk factors include: impaired child-caregiver interaction, lack of adequate stimulation, family poverty, chronic illness in the family, and institutionalization. The postnatal *behavioral* risk factors include: child abuse and neglect, domestic violence, inadequate safety measures, social deprivation, and difficult child behaviors. Finally, the postnatal *educational* risk factors include: impaired parenting, delayed diagnosis, inadequate early intervention services, inadequate special education services, and inadequate family support. Any of these risk factors can and often does contribute etiologically to mental retardation if it results in impaired functioning sufficient to meet the criteria for such a diagnosis.

Despite the lower courts' holding, these "environmental factors" are actually markers of mental retardation, as opposed to being signals that an individual's condition is something other than mental retardation. To hold, as the lower courts did, that because of "the undesirable home and social environments to which Hall was subjected and his emotional problems," *see Pet. App.* at 104a-05a, his adaptive deficiencies are not a result of mental retardation is a false dichotomy. That turns the

clinical definition of and etiological bases for mental retardation on their collective heads.

Any determination that an individual is not entitled to *Atkins* protection because the person's low IQ and adaptive deficiencies may have been due to postnatal "environmental factors" improperly ignores etiological considerations that have long been an important part of the psychological and medical consensus in diagnosing mental retardation.

C. The History and Current Uniformity of the Definition and Clinical Understanding of Mental Retardation.

An analysis of the definitions of mental retardation used over the last fifty or more years demonstrates that the three essential elements of mental retardation—limitations in intellectual functioning, behavioral limitations in adapting to environmental demands, and early age of onset—have essentially remained unchanged. *See e.g.*, Ruth Luckasson et al., *Mental Retardation: Definition, Classification, and Systems of Supports* 1 (9th ed. 1992) ("Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18."); American Psychiatric Association, *Diagnostic and Statistical Manual of Mental*

Disorders 14 (2d ed. 1968) ("Mental retardation refers to subnormal general intellectual functioning that originates during the developmental period and is associated with impairment of either learning and social adjustment or maturation, or both."); Rick F. Heber, *A Manual on Terminology and Classification in Mental Retardation: A Monograph Supplement to the American Journal on Mental Deficiency* 3 (1959) ("Mental retardation refers to subaverage general intellectual functioning that originates during the development period and is associated with impairment in one or more of the following: (1) maturation, (2) learning, (3) social adjustment."). These historical definitions exemplify the consistency of the modern definition of mental retardation that the Court adopted in *Atkins*.

Consistency and consensus are also reflected in the clinical definition of mental retardation, and the major elements common to the current definition have been used by professionals in the United States for over 100 years. *See generally* R. C. Scheerenberger, *A History of Mental Retardation: A Quarter Century of Progress* (1983). Additionally, this Court recognized the consensus in statutory definitions of mental retardation which "generally conform to the clinical definitions" of the AAIDD/AAMR and the American Psychiatric Association. *Atkins*, 536 U.S. at 317, n. 22.

Despite this uniformity in clinical communities and throughout many states (and their courts) that have adopted the clinical definition of mental retardation, some lower courts, like those in Texas, have rejected clinical understandings of mental

retardation. In doing so, these courts have erroneously denied *Atkins* claims, either relying on archaic stereotypes about the abilities of people with mental retardation, or misinterpreting the presence of mental retardation because of the contribution of "environmental factors." For example, in *Ex parte Briseno*, 135 S.W.3d 1 (Tex. Crim. App. 2004), discussed in detail *post* at 22-26, the Texas Court of Criminal Appeals cited the clinical definition of mental retardation but then departed from a clinical assessment or diagnosis, especially as it related to evaluating the adaptive behavior criteria. Likewise, in another Texas case, courts denied *Atkins* relief because "evidence of a strength in a particular area of adaptive functioning necessarily shows that the defendant does not have a weakness in that particular area." *Clark v. Quarterman*, 457 F.3d 441, 447 (5th Cir. 2006).

A Florida court also found that a mental retardation diagnosis "was contradictory to the evidence that Brown was engaged in a five-year intimate relationship prior to the crime, that he had his driver's license and drove a car, and that he was employed in numerous jobs including as a mechanic." *Brown v. State*, 959 So.2d 146, 150 (Fla. 2007). And in Mississippi, *Atkins* relief was denied based on what the defendant could do, rather than what he could not. *Wiley v. State*, 890 So.2d 892, 897 (Miss. 2004) ("These reports, affidavits and testimonies do not paint the picture of a retarded person."), *aff'd*, *Wiley v. Epps*, No. 2:00CV130-P-A, 2007 WL 405041, at *34-40 (N.D. Miss. Feb. 2, 2007).

Furthermore, several Texas cases follow the clinically disavowed view that mental retardation and personality disorders are mutually exclusive, *See, e.g., Williams v. Quarterman*, 293 F. App'x 298, 312 (5th Cir. 2008); *Neal v. State*, 256 S.W.3d 264, 274-75 (Tex. Crim. App. 2008), *cert denied*, ___U.S.___, 129 S. Ct. 1037 (2009). A 2008 Louisiana case takes the same erroneous approach. *Brumsfield v. Cain*, No. 04-787-JJB-CN, 2008 WL 2600140 (M.D. La. June 30, 2008) (affirming reasonableness of trial court determination where evidence "indicated that a significant part of Brumfield's difficulties actually stem from his attention deficit disorder . . . which, while it results in an inability to focus, is not equivalent to mental retardation").

These cases demonstrate not only the confusion among some courts about the clinical understandings of mental retardation (despite the historical clinical consensus) but also the necessity of this Court to affirm the holding of *Atkins* and to correct lower courts that have taken this Court's instruction to devise appropriate procedures as tacit permission to improvise non-clinical substantive standards more to their liking.

II. STATES MUST FOLLOW THE *ATKINS v. VIRGINIA* FRAMEWORK THAT ADOPTS A CLINICAL DEFINITION OF MENTAL RETARDATION.

In *Atkins*, this Court held that the consistent wave of state legislative action after *Penry v.*

Lynaugh, 492 U.S. 302 (1989) ("*Penry I*"), established a national consensus against executions of persons with mental retardation. *Atkins*, 536 U.S. at 313-16. Under *Atkins*, the Eighth Amendment protects those individuals who meet the AAIDD/AAMR criteria, or the virtually identical criteria of the *Diagnostic and Statistical Manual of Mental Disorders*. *See* DSM-IV-TR at 41.

Most states and federal courts have faithfully applied *Atkins*, and their decisions correctly reflect the clinical understanding of adaptive functioning deficits. Some have even explicitly rejected the kind of errors made by the Texas courts. For example, the Ohio Supreme Court reversed a lower court determination that the defendant did not have mental retardation where that finding had been based on stereotypes about what an individual with the disability could not do and what he might look like. *State v. White*, 885 N.E.2d 905, 915 (Ohio 2008) ("There was no evidence that bizarre behavior is a necessary attribute of the mentally retarded."); *id.* ("Especially relevant here is . . . [the] observation that retarded individuals '*may look relatively normal in some areas* and have significant limitations in other areas.' ") (emphasis in original).

In Alabama, a federal district court reversed a state court finding of no mental retardation, faulting the prosecution's expert for "look[ing] upon inappropriate conduct as something separate from mental retardation, rather than as indicating a lack of support which has impeded adaptation." *Holladay v. Campbell*, 463 F. Supp. 2d 1324, 1344 (N.D. Ala. 2006), *aff'd*, 535 F.3d 1346 (11th Cir. 2009); *see id.* at

1345 ("This court rejects the argument that willful and anti-social behavior excludes a mental retardation determination. To the contrary, it suggests that a person whose IQ tests strongly indicate mental retardation has not adapted.").

Similarly, in Oklahoma, the Court of Criminal Appeals held that because evidence concerning mental disorders did not offset the alleged adaptive behavior limitations, it was irrelevant to the mental retardation determination. *Lambert v. State*, 126 P.3d 646, 659 (Okla. Crim. App. 2005) ("Mental retardation and mental illness are separate issues. It is possible to be mentally retarded and mentally ill."); *id.* at 651 ("Unless a defendant's evidence of particular limitations is specifically contradicted by evidence that he does not have those limitations, then the defendant's burden is met no matter what evidence the State might offer that he has no deficits in other skill areas.").

As discussed *ante* at 13-14, however, other courts have departed from a faithful application of *Atkins* which requires this Court to reaffirm the principles of *Atkins*.

A. *Atkins* Grants States the Limited Task of Implementing Ways to Evaluate *Atkins* Claims Pursuant to the Clinical Definition of Mental Retardation.

Since *Atkins*, most jurisdictions have adopted and applied the appropriate clinical definitions pursuant to this Court's mandate. As the Sixth Circuit noted, "[W]hen discussing retardation in

Atkins, the Supreme Court cited with approval psychologists' and psychiatrists' 'clinical definitions of mental retardation,' and presumably expected that states will adhere to these clinically accepted definitions when evaluating an individual's claim to be retarded." *Hill v. Anderson*, 300 F.3d 679, 682 (6th Cir. 2002) (citing *Atkins*, 536 U.S. at 309, n. 3). Indeed, courts recognize that this Court limited the states to adopting a definition of mental retardation and the corresponding procedures for evaluating *Atkins* claims embraced by the national consensus.[4]

A few states, however, have taken *Atkins*'s statement that lower courts and state legislatures may adopt their own procedures for "enforc[ing] the constitutional restriction," *Atkins*, 536 U.S. at 317 (quoting *Ford v. Wainwright*, 477 U.S. 399 (1986)), as license to embrace definitions of mental retardation that deviate from, and are more restrictive than, accepted clinical definitions and practices. Yet nowhere in *Atkins* did the Court grant states the right to restrict or narrow the substantive definition of mental retardation, of which there is a clear clinical consensus.

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4 *See, e.g., U.S. v. Cisneros*, 385 F. Supp. 2d 567, 569-70 (E.D. Va. 2005) ("The Court's decision in *Atkins* makes clear, however, that the prohibition on execution applies to all defendants that 'fall within the range of mentally retarded offenders about whom there is a national consensus.' Accordingly, when adopting a statutory definition of mental retardation, states cannot adopt a definition that fails to protect any individuals who have mental retardation under a definition embraced by a national consensus.") (internal citations omitted).

Indeed, it was in *Ford*, upon which the Court in *Atkins* analogized, where the Court limited the implementation of procedures for ensuring constitutional safeguards by the very substance of those safeguards. *Ford*, 477 U.S. at 405. Inviting departure from the substance of those safeguards in implementing procedures to diagnose mental retardation was not and could not be the intention of this Court. These gross deviations from the clinical understanding of mental retardation have had the effect of excluding some individuals who clearly fall within the class protected by *Atkins*. The reluctance of Texas courts to follow this Court's mandate in *Atkins* echoes their decade-long resistance to this Court's clear teachings in *Penry I*. *See, e.g.*, *Tennard v. Dretke*, 542 U.S. 274 (2004); *Penry v. Johnson*, 532 U.S. 782 (2001) ("*Penry II*").

B. Reliance on Clinical Judgment of Trained Mental Retardation Experts Promotes Accurate and Just Assessments of *Atkins* Claims.

Under *Atkins*, criminal defendants are not subject to the death penalty if they have mental retardation. This elevates the question of whether a defendant has mental retardation not just to a constitutional question but to a life or death issue. Courts have recognized, however, that making an accurate judicial assessment of mental retardation claims is not a simple task.

Some states rightly require expert testimony in *Atkins* hearings. *See e.g.*, *State v. Dunn*, 831 So. 2d 862, 887 (La. 2002) (remanding for *Atkins* hearing

"during which the court will be guided by evaluation and diagnosis made by those with expertise in diagnosing mental retardation."); *Wiley v. State*, 890 So. 2d at 895 (Miss. 2004) (Mississippi law requires *Atkins* claimant to submit expert testimony that he or she has mental retardation under AAMR or APA definitions); *see also Ake v. Oklahoma*, 470 U.S. 68, 82 (1985) (indigent defendant entitled to assistance of psychiatrist because, "without the assistance of a psychiatrist to conduct a professional examination on issues relevant to the defense, to help determine whether the insanity defense is viable, to present testimony, and to assist in preparing the cross-examination of a State's psychiatric witnesses, the risk of an inaccurate resolution of sanity issues is extremely high. With such assistance, the defendant is fairly able to present at least enough information to the jury, in a meaningful manner, as to permit it to make a sensible determination.").

At least one court in Texas has recognized the importance of clinical judgment in *Atkins* inquiries. *See Williams v. Dretke*, Civ. Action No. H-04-2945, 2005 U.S. Dist. LEXIS 34438, at *18-*19 (S.D. Tex. July 15, 2005), *aff'd in part, remanded in part*, 293 F. App'x 298 (5th Cir. 2008) (providing "funding for expert assistance" to inmate with colorable *Atkins* claim). This case, however, is the exception that proves the Texas rule – that, based on *Briseno*, discussed *infra*, and the case at bar, Texas does not require and, indeed, departs from clinical judgment in *Atkins* inquiries.

1. Properly Trained Clinicians Provide the Most Reliable Evidence for Fact-Finder's Determination of Mental Retardation.

Proper diagnosis of mental retardation requires a complex scientific analysis of cognitive ability, adaptive functioning, and personal history. No element of the definition predominates. The application of clinical judgment is crucial because the definition of mental retardation requires a multi-faceted scientific analysis of an individual's cognitive abilities and adaptive skills and deficits observed in a variety of typical environments.[5]

Clinical experts typically measure cognitive ability and adaptive behavior by administering tests. Importantly, using clinical judgment, trained clinical experts also compile and evaluate a detailed history of the defendant's adaptive skills and deficits across a spectrum of typical environments. This history is based on available academic, medical or other records, and interviews of the defendant and non-experts who have observed the defendant. Clinical judgment is the reason lay observation can assist a clinical professional in informing his judgment about an individual's adaptive deficits or skills, even

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[5] The issue of mental retardation is fundamentally different from the issue of competency to stand trial, in which trial courts can use common sense and their own observations (along with expert opinions) to assess whether the defendant can assist in his or her own defense. In contrast, mental retardation is not susceptible to evaluation by non-experts, and the disability can be assessed only through scientific tests administered by experienced professionals in the field using their training, experience, and clinical judgment.

though the same observation, standing alone, has little probative value. Clinical judgment allows complex, sometimes seemingly contradictory information to be put in the proper perspective to determine if an individual has mental retardation.

2. *The Dangers and Unreliability of Lay Persons' Assessments Regarding an Individual's Diagnosis of Mental Retardation.*

Non-expert witnesses who lack the necessary clinical background in mental retardation are just as likely to confuse the fact-finder as to assist it. Despite the fact that mental retardation is a permanent condition, isolated adaptive skills and deficits can change over time through life experience and learning, or by virtue of personalized supports. Lay observations should be limited to factual history since isolated observations of adaptive behaviors are of no probative value with respect to diagnosis. The non-expert lacks an understanding of the continuum of skills and deficits that an individual may exhibit across different aspects of everyday life. Non-expert recollections about a defendant's adaptive behavior also may be inaccurate or biased. Non-experts frequently have limited opportunities to observe the defendant, or have multiple observations of the defendant in a single setting, which are of limited value.

An expert clinician, on the other hand, understands that "limitations in adaptive skills should be documented within the context of ordinary community environments typical of the person's age

peers[.]" AAID 2010 at 16. Expert analysis of observations across multiple environments and time periods, and the application of clinical judgment, filters potential inaccuracies and biases of non-experts and leads to a more complete and accurate picture of the defendant's adaptive deficits.

Ultimately, fact-finders are more likely to assess an individual's mental retardation accurately if they rely on evidence provided by properly trained experts. Reliance on non-expert opinions and evidence should be carefully circumscribed.

C. Texas's Departure from the Clinical Standard for Assessing and Diagnosing Mental Retardation Results in Under-Protection of *Atkins* Rights.

1. The Texas Court of Criminal Appeals' Briseno *Decision.*

In 2004, the Texas Court of Criminal Appeals decided *Briseno*, the currently controlling authority in Texas for *Atkins* cases. In that singular case, the Texas Court of Criminal Appeals set a course for *Atkins* jurisprudence that would impact the case at bar as well as many other cases where *Atkins* inquiries are at issue.

In *Briseno*, the Court of Criminal Appeals recognized both the clinical definition of mental retardation of the AAIDD/AAMR and the definition under TEX. HEALTH & SAFETY CODE § 591.003(13). *Briseno*, 135 S.W.3d at 7 ("Under the AAMR definition, mental retardation is a disability

characterized by: (1) "significantly subaverage" general intellectual functioning; (2) accompanied by "related" limitations in adaptive functioning; (3) the onset of which occurs prior to the age of 18. . . . [T]he definition under the Texas Health and Safety Code is similar: '<u>mental retardation</u>' means significantly subaverage general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.") (internal quotations omitted) (emphasis in original). Because the Texas Legislature had yet to define mental retardation specifically for *Atkins* purposes, the Texas Court of Criminal appeals accepted either definition in determining *Atkins* claims. *Id.* at 8.

However, from there, the Texas Court of Criminal Appeals departed from a clinical assessment or diagnosis, especially as it related to evaluating the adaptive behavior criteria. Indeed, the court stated, "The adaptive behavior criteria are exceedingly subjective, and undoubtedly experts will be found to offer opinions on both sides of the issue in most cases." *Id.* at 8. The court continued and listed several "factors" to resolve questions about adaptive behavior. *Id.* at 8-9. These so-called "evidentiary factors" took the form of a list of questions including:

> "• Did those who knew the person best during the developmental stage – his family, friends, teachers, employers, authorities – *think* he was mentally retarded at that time, and, if so, act in accordance with that determination?

> • Has the person formulated plans and carried them through or is his conduct impulsive?
>
> • Does his conduct show leadership or does it show that he is led around by others?
>
> • Is his conduct in response to external stimuli rational and appropriate, regardless of whether it is socially acceptable?
>
> • Does he respond coherently, rationally, and on point to oral or written questions or do his responses wander from subject to subject?
>
> • Can the person hide facts or lie effectively in his own or others' interests?
>
> • Putting aside any heinousness or gruesomeness surrounding the capital offense, did the commission of that offense require forethought, planning, and complex execution of purpose?"

Id. This list of "factors" identified by the Texas Court of Criminal Appeals has no basis of support in the clinical literature or in the understanding of mental retardation by experienced professionals in the field, but nonetheless is being cited by other courts. Indeed, the opinion of the Texas Court of Criminal Appeals in *Briseno*, perhaps because of this so-called list of "factors," has even caught the

attention of courts in other states. *See, e.g., Van Tran v. State*, No. W200501334CCAR3PD, 2006 WL 3327828, at *23-24 (Tenn. Crim. App. Nov. 9, 2006).

Despite the lack of support for the use of these "factors" in diagnosing mental retardation, Texas and a few federal courts continue to erroneously rely on them in judging whether an individual should be afforded protection under *Atkins*. *See, e.g., Williams v. Quarterman*, 293 F. App'x 298, 311-12 (5th Cir. 2008) (relying on *Briseno*'s so-called "evidentiary factors" in deciding whether evidence suggested mental retardation); *Maldonado v. Thaler*, 662 F. Supp. 2d 684, 729-30 (S.D. Tex. 2009) (affirming the state court's use of and its own interpretation of the lay person's assessments of defendant's mental retardation and the evidentiary factors that ultimately guided the court's review under *Atkins*); *Ex parte Van Alstyne*, 239 S.W.3d 815, 820 (Tex. Crim. App. 2007) (referring to state factors set forth in *Briseno* for determining *Atkins* claims as "non-diagnostic criteria"). *Briseno* has planted a seed that legal principles can be built out of preconceived notions of what mental retardation looks like to the lay person and that their conclusions will be followed even if they are flatly contrary to science.

Briseno's holding is demonstrative of the growing problem in Texas and elsewhere of permitting non-expert assessments of mental retardation to have independent and significant weight in the diagnosis of mental retardation under *Atkins*. Though the district court in this case did not explicitly rely on *Briseno* in rendering its erroneous decision, it mimicked *Briseno*'s methodology. *Briseno*'s reliance

on these "evidentiary factors" that have no basis in the clinical diagnosis of mental retardation is infectious and has the potential to render the protections afforded by *Atkins* meaningless. Because the legal standard under *Atkins is* the diagnosis itself, an *Atkins* determination should not be based on a list of jury charge-style questions with no clinical foundation whatsoever.

2. *In the Case at Bar, the Lower Courts Failed to Follow the Correct Clinical Definition of Mental Retardation.*

Petitioner rightly concludes that a split exists among the states on whether sub-70 IQ scores and adaptive deficiencies that are attributable, at least in part, to "environmental factors" satisfy *Atkins*. But it is Texas' position that they do not satisfy *Atkins* that is erroneous. Indeed, the holdings by the lower courts in this case are part of a growing problem where a few courts' attempts to avoid *Atkins* protection are causing confusion in what should be settled law. As discussed *ante* at 25, since *Briseno*, Texas courts (along with courts in other states) have been failing to follow the correct clinical definition of mental retardation, which necessarily involves a clinical diagnosis or assessment of mental retardation by an expert.

Rather than follow the clinical definition of mental retardation, the lower courts in this case relied on conclusions against the clinical consensus in diagnosing mental retardation. For example, the lower courts embraced the notion that "environmental factors" could exclude someone from

Atkins protection by asserting that his or her adaptive deficiencies were not due to mental retardation. These same postnatal "environmental factors," could have also, the courts reasoned, contributed to a lower IQ score. The lower courts' line of reasoning demonstrates the disconnect in the courts between the condition of mental retardation itself and the etiology of the condition. If the lower courts in Texas and elsewhere continue to present a false dichotomy to deny protection under *Atkins*, the very constitutional limitations recognized by this Court will be eviscerated under the guise of implementing *Atkins*-mandated procedures.

The courts below clearly misunderstood the definition of mental retardation and wrongly believed that Petitioner was not entitled to relief under *Atkins* because his low IQ score and adaptive deficiencies were caused, possibly, by postnatal "environmental factors." Such a conclusion is unsupported by the clinical literature and, if allowed to stand, will render a significant number of individuals with mental retardation at risk of being wrongfully sentenced to death and executed. If *Atkins* is to have meaning, this Court should grant certiorari to correct this fundamental and impermissible misunderstanding of the clinical definition of mental retardation.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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